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# The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia

By DAVID ORENTLICHER\*

According to conventional wisdom, the United States Supreme Court last year reaffirmed the long-standing distinction between "passive" forms of physician aid-in-dying, like the withdrawal of life-sustaining treatment, and "active" forms of physician aid-in-dying, like assisted suicide and euthanasia.<sup>1</sup> At first glance, this seems to be what happened. By a 9-0 vote in *Washington v. Glucksberg*,<sup>2</sup> the Court rejected the claim that just as substantive due process includes a right to refuse life-sustaining treatment, it also includes a right to physician-assisted suicide. Similarly, by a 9-0 vote in *Vacco v. Quill*,<sup>3</sup> the Court rejected the claim that it is a denial of equal protection when some terminally ill persons can end their lives with a refusal of life-sustaining treatment while other terminally ill persons can-

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1. I put the words passive and active in quotation marks because withdrawals of life-sustaining treatment involve action. Turning off a ventilator, for example, is an action. Nevertheless, writers commonly characterize withdrawals of treatment as passive, and it is useful to have different terms to distinguish between withdrawal (or withholding) of treatment on the one hand and assisted suicide and euthanasia on the other hand.

Withdrawal of life-sustaining treatment refers to situations in which physicians discontinue the provision of health care (for example, ventilator, dialysis, feeding tube) that is necessary to sustain a patient's life. Physician-assisted suicide refers to situations in which a physician provides a patient with a lethal dose of medication (or a prescription for the medication), and the patient takes the medication immediately or at a later time. Euthanasia refers to situations in which a physician administers a lethal dose of medication to bring about a patient's death.

2. 117 S. Ct. 2258 (1997).

3. 117 S. Ct. 2293 (1997).

not end their lives with physician-assisted suicide.<sup>4</sup> The Court held that, as a constitutional matter, the distinction between treatment withdrawal and suicide assistance is sufficiently important to justify a right to the former, but not the latter; the states must permit patients to refuse life-sustaining treatment, but they need not permit patients to obtain a prescription for an overdose of barbiturates or other drugs from their physicians.<sup>5</sup>

In fact, however, the conventional wisdom is wrong. In its effort to respond to the moral sentiments that drive right-to-die law, the Court preserved the distinction between treatment withdrawal and suicide assistance only by breaking down the distinction between treatment withdrawal and euthanasia. Faced with the argument that assisted suicide is the only way to respond to the severe suffering of some dying patients, members of the Court observed that these patients can turn to the alternative of terminal sedation.<sup>6</sup> Often, however, terminal sedation is essentially a form of euthanasia.

In conceding, even encouraging, the availability of terminal sedation, the Court not only blurred the formal distinction between treatment withdrawal and euthanasia, it also undermined some of the important arguments against legalizing assisted suicide or euthanasia. In particular, by implicitly concluding that terminal sedation can be employed by physicians without significant abuse, the Court undermines the objection to assisted suicide and euthanasia that their legalization would be followed by significant abuse.

More importantly, the Court's decision leaves society with a constitutional scheme that is ethically more problematic than if the Court had found a right to physician-assisted suicide. Terminal sedation not only serves fewer of the purposes of right-to-die law, it also poses greater risks for patient welfare than does physician-assisted suicide.<sup>7</sup>

## I. The Court's Decision

The Supreme Court's rejection of a right to assisted suicide was widely expected.<sup>8</sup> In the context of a substantive due process jurispru-

4. *Id.* at 2297-98.

5. *See id.* at 2301-02.

6. *See id.* Terminal sedation is offered to dying patients who are suffering greatly and for whom conventional treatments are inadequate to relieve their suffering. With terminal sedation, patients are sedated-sometimes to unconsciousness-so that they are no longer aware of their suffering. For further discussion, see *infra* text accompanying notes 41-50.

7. *See* discussion *infra* Part IV.

8. *See, e.g.,* BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 1184 (3d ed. 1997) (observing that "the heavy betting odds" were that the Supreme Court would reject a constitutional right to assisted suicide).

dence that has seen little expansion<sup>9</sup> and significant contraction<sup>10</sup> in recent years, the Court was not likely to recognize a right that would break an important taboo in medicine. Moreover, recognizing a right to assisted suicide would have required the Court to be far more activist than when it recognized a right to refuse life-sustaining treatment. By 1990, when the Court acknowledged the right to refuse treatment in *Cruzan*,<sup>11</sup> fourteen years had passed since the New Jersey Supreme Court's decision in *In re Quinlan*,<sup>12</sup> the first right-to-die case. Such a long passage of time allowed the Court to rely on the "laboratory" of state experimentation<sup>13</sup> in evaluating the implications of a right to refuse life-sustaining treatment. Moreover, by acknowledging a right to refuse treatment, but deferring to the states on the procedural rules for withdrawing treatment from incompetent persons,<sup>14</sup> the *Cruzan* decision simply ratified the existing body of state

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9. The Court has recognized a right to refuse unwanted medical treatment in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 279 (1990) (involving life-sustaining treatment) and *Washington v. Harper*, 494 U.S. 210, 221 (1990) (involving antipsychotic drugs), but has generally rejected claims for new substantive due process rights in the past 10-15 years. See, e.g., *Bowers v. Hardwick*, 478 U.S. 186 (1986) (holding that there is no constitutional right to engage in homosexual sodomy).

10. The most important change in substantive due process law in the past decade was the Court's narrowing of the right to abortion in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), in which the Court held that states could limit the right to abortion before viability as long as they did so without imposing an undue burden on the exercise of the right.

11. The Court in *Cruzan* only assumed "for purposes of [the] case... that the... Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279. However, in *Glucksberg*, the majority wrote that in *Cruzan*, it not only had assumed but also "strongly suggested" that there is a constitutional right to refuse life-sustaining treatment. *Glucksberg*, 117 S. Ct. at 2267. In any event, the lower courts have read *Cruzan* as establishing a constitutional right to refuse life-sustaining treatment. See, e.g., *Browning v. Herbert*, 568 So. 2d 4, 10 (Fla. 1990) (citing *Cruzan* holding that "[a] competent individual has the constitutional right to refuse medical treatment regardless of his or her medical condition").

12. 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976) (permitting the withdrawal of a respirator from a permanently unconscious woman).

13. The laboratory of state experimentation theme comes from *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

14. Although state courts before *Cruzan* had come to a consensus that competent adults enjoyed a right to refuse life-sustaining treatment and that the right survived when the patient lost decision-making capacity, there was considerable variation among the states in terms of the standards that had to be satisfied before treatment could be withdrawn from an incompetent person. Courts either looked to statements made by a patient while still competent, allowed the family to decide based on its sense of what the patient would want, or turned to the best interests of the patient. In addition, some states had different standards depending on the patient's condition and the treatment at issue. For example, procedural rules were stricter for patients who were neither terminally ill nor permanently unconscious. They were also stricter for removals of feeding tubes than for removals of ventilators or other treatments. All of these approaches are permitted under

law and practices that had been employed in hospitals throughout the country for many years with wide public acceptance.<sup>15</sup> Indeed, the *Cruzan* Court was able to recognize a constitutional right while upholding the challenged state action.<sup>16</sup> In contrast, recognition of a right to physician-assisted suicide would have meant overturning bans on that practice in more than forty states. In addition, because physician-assisted suicide came to the Court relatively early in this country's experience with the practice,<sup>17</sup> the Court could have found a right to assisted suicide only by preempting state experimentation.<sup>18</sup>

Not only was the Court's rejection of a constitutional right predictable, so was its logic. The Court undertook its usual review of Anglo-American legal tradition,<sup>19</sup> found a tradition in which assisted suicide has

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*Cruzan*. See generally David Orentlicher, *The Right to Die After Cruzan*, 264 JAMA 2444 (1990).

15. See generally *id.* It is not surprising that the Court was reflecting rather than changing public sentiments. The Court has not often gotten too far out in front of the majority. See Michael J. Klarman, *Rethinking the Civil Rights and Civil Liberties Revolution*, 82 VA. L. REV. 1, 7-18 (1996). The Court may have done somewhat more than simply ratify existing law. It may have overridden a few very restrictive state court decisions, such as *In re Grant*, 747 P.2d 445, 451 (Wash. 1987) (en banc), modified, 757 P.2d 534 (1988), in which the court recognized a right to refuse life-sustaining treatment, but denied a right for incompetent persons to have feeding tubes withdrawn.

16. Although the Court assumed for purposes of its analysis that Nancy Cruzan had a right to have her nutrition and hydration withdrawn, it upheld Missouri's imposition of a feeding tube on the ground that the State could require clear and specific evidence of the patient's wishes before allowing the discontinuation of life-sustaining treatment. See 497 U.S. at 280-87. The Missouri Supreme Court had concluded that there was insufficient evidence that Ms. Cruzan would want to have food and water withheld. See *Cruzan v. Harmon*, 760 S.W.2d 408, 424, 426 (Mo. 1988) (en banc).

17. To be sure, physicians probably have been assisting the suicides of their dying patients for generations. However, such practices have been hidden from public scrutiny. The only public experience with assisted suicide has been with Dr. Jack Kevorkian, a retired pathologist living in Michigan, who has assisted dozens of suicides. See Brian Harmon, *Kevorkian: I'll Put Law on Trial: Suicide Advocate Says He'll Fight Attempts To Rein Him In*, DETROIT NEWS, Jan. 1, 1998, at C1.

For recent surveys documenting physician participation in assisted suicide, see generally Diane E. Meier, et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193 (1998); Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919 (1996); Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310 (1996).

18. As to why the Court granted certiorari rather than waiting for a period of state experimentation to pass, it may have felt that the possibility of state experimentation had already been preempted in large part by the Second Circuit in *Quill* and the Ninth Circuit in *Glucksberg*, both recognizing a constitutional right to physician-assisted suicide.

19. In his majority opinion, Justice Rehnquist wrote, "We begin, as we do in all due-process cases, by examining our Nation's history, legal traditions, and practices." *Glucksberg*, 117 S. Ct. at 2262.

been illegal,<sup>20</sup> and concluded that it therefore had an insufficient basis for subjecting prohibitions of assisted suicide to heightened scrutiny.<sup>21</sup> Accordingly, the Court applied rational basis review.<sup>22</sup> Under rational basis review, laws banning assisted suicide easily pass muster. As the Court observed, there are important risks of abuse associated with assisted suicide: patients choosing suicide may be depressed or coerced, and society may undervalue the lives of the terminally ill, disabled, and elderly.<sup>23</sup> A state's prohibition of assisted suicide is rationally related to preventing these potential abuses.<sup>24</sup>

The Court's opinion becomes most interesting, I think, in its response to the concern about patient suffering. In attempting to address the needs of suffering patients, the Court develops a doctrine that fails to maintain a distinction in the law between treatment withdrawal and euthanasia. To illustrate this, I now turn to an analysis of the Solicitor General's amicus brief in *Glucksberg* and the responses by the Court to the Solicitor General's argument.

#### A. The Solicitor General's Brief in *Glucksberg*<sup>25</sup>

Rather than drawing on *Cruzan* to argue for a right to choose the circumstances of one's death or on *Planned Parenthood v. Casey*<sup>26</sup> to argue

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20. See *id.* at 2262-67.

21. See *id.* at 2269.

22. See *id.* at 2271. To survive rational basis review, a law need serve only a "legitimate" state interest. In addition, there need only be a plausible basis for believing that the law will serve the state's interest. Stricter standards of review require an "important" or "compelling" state interest and that the law be "substantially related" to the state's interest or be "narrowly tailored" to serve the state's interest.

23. See *id.* at 2272-73.

24. See *id.* at 2272-75. See also, Cass Sunstein, *The Right to Die*, 106 YALE L.J. 1123, 1142-46 (1997). The rejection of the equal protection claim followed a similar path. In the absence of a due process right to assisted suicide, a state's distinction between treatment withdrawal and assisted suicide need only satisfy rational basis review. See *Quill*, 117 S. Ct. at 2297 n.5. The Court cited several reasons for the distinction. For example, when life-sustaining treatment is withdrawn, the Court said, the patient dies from the underlying disease. See *id.* at 2298. In contrast, with assisted suicide, the patient dies from a drug overdose. See *id.* Moreover, according to the Court, while the physician may only intend to respect a patient's wishes to be free of unwanted treatment when life-sustaining treatment is withdrawn, a physician assisting a suicide must necessarily intend that the patient die. See *id.* at 2298-99.

25. More precisely, the brief was filed by the acting Solicitor General. See Brief for the United States as *Amicus Curiae* Supporting Petitioners at 14, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (reprinted on the web page of the University of Pennsylvania's Center for Bioethics at <http://www.med.upenn.edu/~bioethic/PAS>). The Solicitor General also filed a brief in *Quill* arguing that states can constitutionally distinguish between the withdrawal of life-sustaining treatment and physician-assisted suicide. See Brief for the United States as *Amicus Curiae* Supporting Petitioners, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) (reprinted on the webpage of the University of Pennsylvania's Center for Bioethics at <http://www.med.upenn.edu/~bioethic/PAS>).

for a right to make decisions about important personal matters, the Solicitor General argued for the existence of a Fourteenth Amendment right for terminally ill persons to avoid both "severe physical pain" and "the despair and distress that comes from physical deterioration and the inability to control basic bodily and mental functions."<sup>27</sup> The Solicitor General observed that prior Supreme Court cases stood for the proposition that a Fourteenth Amendment liberty interest is implicated "when the State itself inflicts severe pain or suffering on someone."<sup>28</sup> In addition, the Solicitor General argued, a liberty interest is implicated when the state blocks a person from seeking relief from severe pain or suffering.<sup>29</sup> Thus, for example, a state could not prevent a person with an illness causing extreme physical pain from obtaining medications to alleviate the pain, nor could a state prevent a person with severe mental depression from obtaining prescription drugs to treat that condition.<sup>30</sup> As authority for this position, the Solicitor General cited the discussion in *Casey* in which the Court justified a right to abortion in part to ensure that women are not forced to endure the physical and mental suffering that can accompany pregnancy.<sup>31</sup>

## B. The Court's Response to the Solicitor General

The Court's response to the Solicitor General is found in the concurring opinions of Justices O'Connor and Breyer; the majority opinion did

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26. 505 U.S. 833 (1992) (reaffirming, but narrowing, the right to abortion recognized in *Roe v. Wade*, 410 U.S. 113 (1973)).

27. Brief for the United States as *Amicus Curiae* Supporting Petitioners at 14, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110).

28. *Id.* (citing *Ingraham v. Wright*, 430 U.S. 651, 674 (1977) (involving corporal punishment of children in the schools) and *Hudson v. McMillian*, 503 U.S. 1, 9-10 (1992) (involving beating of an inmate by prison guards)).

29. *See id.* at 15.

30. *See id.*

31. *See id.* (citing *Casey*, 505 U.S. at 852). Other parties also raised the interest of the dying patient in avoiding pain, but did so more in terms of explaining why the decision to end one's life is an important personal decision that justifies constitutional protection. *See, e.g.*, Brief of Respondents at 13, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (reprinted on the web page of the University of Pennsylvania's Center for Bioethics at <http://www.med.upenn.edu/~bioethic/PAS>) (quoting *Compassion in Dying v. Washington*, 79 F.3d 790, 813 (9th Cir. 1996) (en banc), *rev'd*, *Glucksberg*, 117 S. Ct. 2258 (1997) (observing that "few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain.")).

Although the Solicitor General argued in favor of a Fourteenth Amendment liberty interest in assisted suicide, he also concluded that states should be able to prohibit assisted suicides entirely. *See id.* at 19-32. In the opinion of the Solicitor General, states could decide that opening the door to assisted suicide for terminally ill persons would pose too great a risk of suicide for persons who are not competent, who are not terminally ill, whose desire for suicide would abate with treatment for mental depression or with validation from others of the value of their life, or who are vulnerable to influence by family members and physicians concerned with the financial and psychological burdens of caring for the patient. *See id.* at 20-28.

not explicitly address the Solicitor General's argument. In her concurrence, Justice O'Connor agreed with the majority's conclusion that "there is no generalized right to 'commit suicide.'"<sup>32</sup> However, she noted, the respondents had argued a narrower point—that terminally ill persons who are suffering greatly should be able to choose assisted suicide in order to gain relief from their suffering.<sup>33</sup> Rather than deciding whether this narrower right exists, Justice O'Connor observed that, even if such a right did exist, a prohibition on assisted suicide would not violate the right.<sup>34</sup> Dying patients who are experiencing great pain have "no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, *even to the point of causing unconsciousness and hastening death.*"<sup>35</sup> Justice O'Connor's opinion was joined by Justices Ginsburg and Breyer.<sup>36</sup>

In his separate concurrence, Justice Breyer echoed Justice O'Connor's argument. In his view, there is arguably a "right to die with dignity," which includes as one of its core aspects a right to avoid "unnecessary and severe physical suffering."<sup>37</sup> According to Justice Breyer, however, that right does not justify assisted suicide. A successful claim to assisted suicide would require a showing of a need to avoid "severe physical pain," and any physical pain can be avoided with either pain control medications or "sedation which can end in a coma."<sup>38</sup>

For purposes of my argument, the key point made by Justices O'Connor and Breyer, and joined by Justice Ginsburg,<sup>39</sup> is the rejection of a right to assisted suicide on the ground that treatment is available to re-

32. *Glucksberg*, 117 S. Ct. at 2303 (O'Connor, J., concurring).

33. *See id.*

34. *See id.*

35. *Id.* (emphasis added). The American Medical Association (AMA) assured the Court that this was the case. According to the AMA's *amicus* brief:

The pain of most terminally ill patients can be controlled throughout the dying process without heavy sedation or anesthesia. For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or weeks of life to prevent the patient from experiencing severe pain.

Brief of the American Medical Association et al., as *Amici Curiae* in Support of Petitioners at 6, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (citations omitted).

36. More precisely, Justice Ginsburg concurred "in the Court's judgments substantially for the reasons stated in" Justice O'Connor's concurrence, and Justice Breyer joined Justice O'Connor "except insofar as [her opinion] join[ed] the opinions of the Court." *Glucksberg*, 117 S. Ct. at 2303 n.\*.

37. *Id.* at 2311 (Breyer, J., concurring).

38. *Id.* at 2311-12 (Breyer, J., concurring).

39. While Justices Stevens and Souter did not discuss whether there is a constitutional right to obtain relief from severe suffering, their opinions suggest they would be sympathetic to that view. *See id.* at 2291 n.16 (Souter, J., concurring) (observing that there are important reasons for distinguishing assisted suicide from both aggressive pain control and the withdrawal of life-sustaining treatment); *id.* at 2308 (Stevens, J., concurring) (stating that "[e]ncouraging the development and ensuring the availability of adequate pain treatment is of utmost importance").



lieve the suffering of any dying patient, with the most severe suffering avoided by sedating the patient into unconsciousness or even coma.<sup>40</sup> By relying on the availability of such heavy sedation, the Justices rejected assisted suicide only by embracing euthanasia.<sup>41</sup>

## II. Terminal Sedation

When Justice O'Connor wrote about palliative care causing unconsciousness, and Justice Breyer wrote about physicians sedating patients into a coma, they were referring to the same practice, a practice commonly characterized as "terminal sedation." A description of terminal sedation follows.

At the end stage of life, terminally ill patients may develop intolerable symptoms of pain, shortness of breath, agitated delirium or persistent vomiting that are refractory to the usual therapies.<sup>42</sup> Intolerable pain may be caused by a number of conditions, including cancer that has spread to the spine with collapse of the vertebral bodies, intestinal obstruction, or severe headache due to massive intra-cerebral edema (i.e., massive build-up of fluid in the brain).<sup>43</sup> Intolerable shortness of breath also may be caused by a number of conditions, including emphysema, lung and other

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40. All patients in a coma are unconscious, but not all unconscious patients are in a coma. In a coma, there is loss of function of the part of the brain that is responsible for consciousness. There is also loss of function of parts of the brain that are responsible for breathing, sleep-wake cycles, reflexes and other unconscious activity. Accordingly, coma is sometimes described as a deep unconscious state. Brain death is even further along the spectrum of loss of brain function. In brain death, there is a nearly total loss of unconscious brain function in addition to the loss of consciousness.

41. Although the majority opinion in *Glucksberg* did not explicitly address the Solicitor General's argument that the right at stake is the right to avoid suffering, the Court did signal its approval of sedation, even into coma, in *Quill*. There, the majority rejected the claim that such heavy sedation "is covert physician-assisted suicide." *Quill*, 117 S. Ct. at 2301 n.11. The effect of the Court's opinions in *Glucksberg* and *Quill* has been to give a green light to physicians who address their patients' suffering by deeply sedating them. See, e.g., Sheryl Gay Stolberg, *Cries of the Dying Awaken Doctor to a New Approach*, N.Y. TIMES, June 29, 1997, at A1 (noting "the Supreme Court put its imprimatur on th[e] practice" of aggressive palliative care, even though it "might hasten a patient's death," as long as "the intent is only to ease pain").

42. See Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10(2) J. PALLIATIVE CARE 31 (1994); William R. Greene & William H. Davis, *Titrated Intravenous Barbiturates in the Control of Symptoms in Patients with Terminal Cancer*, 84 S. MED. J. 332 (1991); Timothy E. Quill & Robert V. Brody, "You Promised Me I Wouldn't Die Like This!": A Bad Death as a Medical Emergency, 155 ARCH. INTERN. MED. 1250 (1995); Subha Ramani & Anand B. Karnad, *Long-Term Subcutaneous Infusion of Midazolam for Refractory Delirium in Terminal Breast Cancer*, 89 S. MED. J. 1101 (1996).

43. See Cherny & Portenoy, *supra* note 42, at 32.

cancers, and congestive heart failure.<sup>44</sup> In cases of intolerable and refractory suffering, adequate relief can be obtained only by sedating the patients, often into unconsciousness, so that they no longer are able to feel their pain or other suffering.<sup>45</sup> Although the frequency of intolerable and refractory symptoms is uncertain, studies have found their existence in 10-50% of terminally ill patients referred for palliative care.<sup>46</sup>

With terminal sedation, narcotics (e.g., morphine), benzodiazepine sedative drugs (e.g., Valium), barbiturates (e.g., amobarbital) and/or major tranquilizing drugs (e.g., Haldol or Thorazine) are used to sedate the patient.<sup>47</sup> The sedation is maintained until the patient dies, usually within a few days, either from the underlying terminal illness, or from a second step that is often part of terminal sedation—the withholding of nutrition and hydration.<sup>48</sup> Because the sedation leaves the patient with a depressed level of consciousness and stopping the sedation would only result in the patient reexperiencing the suffering, the patient frequently agrees to have food and water withheld rather than having life prolonged for a short time. In cases in which terminal sedation shortens the patient's life, it usually does so by hours or days. For some patients, however, life is shortened by as much as several weeks.<sup>49</sup>

At first glance, terminal sedation seems consistent with well accepted practices. It is appropriate for physicians to treat the pain and suffering of patients aggressively, even if doing so increases the likelihood that a patient will die. It is also appropriate for patients to refuse life-sustaining treatment, including food and water. Upon closer examination, however, terminal sedation is at times essentially "slow euthanasia."<sup>50</sup>

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44. See David B. Reuben & Vincent Mor, *Dyspnea in Terminally Ill Cancer Patients*, 89 CHEST 234 (1986).

45. See, *supra* note 35 and accompanying text.

46. See Cherny & Portenoy, *supra* note 42, at 32; see also ROBERT E. ENCK, THE MEDICAL CARE OF TERMINALLY ILL PATIENTS 166-72 (1994). Because patients referred for palliative care are a minority of all dying patients, the number of patients receiving terminal sedation is relatively small.

47. See Cherny & Portenoy, *supra* note 42, at 35; Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 NEW ENG. J. MED. 1678 (1992).

48. See Timothy E. Quill, et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, 278 JAMA 2099, 2100 (1997).

49. See *id.*

50. It is "slow" euthanasia because the patient dies after a few hours or days rather than almost immediately. The term slow euthanasia has previously been used to describe other forms of euthanasia. See, e.g., J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, 12(4) J. PALLIATIVE CARE 21 (1996) (using "slow euthanasia" to refer to the practice of increasing the dose of palliative medications "not for the purpose of easing identifiable discomfort but with the expectation of hastening death gradually").

### III. Terminal Sedation as a Form of Euthanasia

In many cases, terminal sedation amounts to euthanasia because the sedated patient often dies from the combination of two intentional acts by the physician—the induction of stupor or unconsciousness and the withholding of food and water.<sup>51</sup> Without these two acts, the patient would live longer before eventually succumbing to illness.<sup>52</sup> In other words, if the sedation step and the withholding of nutrition and hydration step are viewed as a total package, we have a situation in which a patient's life is ended by the active intervention of a physician.

It might be argued that these deaths by terminal sedation are not deaths by euthanasia because they result from the withdrawal of nutrition and hydration. As courts, including the United States Supreme Court, have consistently recognized, it is ethically and legally permissible for patients to die because artificial nutrition and hydration have been discontinued.<sup>53</sup>

Although terminal sedation deaths from dehydration or starvation appear in form to be a type of treatment withdrawal, in principle, they are more like a variation of euthanasia. We permit the withdrawal of life-sustaining treatment, but reject assisted suicide and euthanasia because, as the *Quill* Court argued, the patient dies from the underlying disease, not from the active intervention of the physician.<sup>54</sup> The patient's illness is al-

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51. It is true that the withholding of food and water is an "omission" and therefore a different kind of action than an injection of a drug, and it is also true that the law often distinguishes "acts" from "omissions." Nevertheless, as Justice Scalia has observed, the line between appropriate and inappropriate patient deaths is not defined simply by the distinction between action and inaction. See *Cruzan*, 497 U.S. at 296 (Scalia, J., concurring) (observing that if "one may not kill oneself by walking into the sea," then one may also not "sit on the beach until submerged by the incoming tide"). See also Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2028-29 (1992) (observing that the distinction between acts and omissions is not always clear and that the act-omission distinction does not coincide with the moral-immoral distinction).

Moreover, ethicists have long argued that withholdings are worse than withdrawals since treatment withdrawals at least come after a trial of the therapy while withholdings deny the chance for an unexpected recovery.

52. Although the patient's life may be shortened by only hours, days or weeks, this does not affect the determination of whether the death is caused by euthanasia. Shooting people on their deathbeds is still murder.

53. See, e.g., *Cruzan*, 497 U.S. 261 (1990); *Browning v. Herbert*, 568 So. 2d 4 (Fla. 1990) (permitting the withdrawal of a feeding tube from a woman with severe brain damage following a stroke); *In re Jobes*, 529 A.2d 434 (N.J. 1987) (permitting the withdrawal of a feeding tube from a woman in a persistent vegetative state); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626 (Mass. 1986) (permitting the withdrawal of a feeding tube from a man in a persistent vegetative state).

54. According to the Court in *Quill*, "When a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication." 117 S. Ct. at 2298. While I have discussed my problems with this distinction, see David Orentlicher, *The Legalization of*

lowed to take its natural course.<sup>55</sup> Patients with severe emphysema die after the removal of their ventilators because their lung disease has made them unable to breathe. Similarly, a patient in a persistent vegetative state dies after the removal of a feeding tube because the patient's brain damage has rendered the patient unable to eat food or drink fluids. This is not, however, what happens with terminal sedation accompanied by the withholding of nutrition and hydration. In such a case, the patient dies from the induced stupor or coma. It is the physician-created state of diminished consciousness that is responsible for the patient's inability to eat, not the natural progression of the patient's underlying disease.

Proponents of terminal sedation might defend the practice by citing the principle of double effect. Under that principle, physicians may take steps that might hasten a patient's death, as long as the steps are a reasonable effort to treat the patient's suffering and the patient's death is not intended.<sup>56</sup> For example, it is permissible to give analgesics or sedatives to alleviate a patient's pain, even if the drugs might halt the patient's breathing. The principle of double effect, however, only justifies the sedation part of terminal sedation. We cannot justify the withdrawal of food and water component of terminal sedation, because that step does nothing to relieve the patient's suffering, but rather serves only to bring on the patient's death. If it is argued that the withdrawal of food and water is a permissible act, then we are back to the previous response that the reason it is permissible is that the patient's inability to eat or drink results from an underlying disease.

A third potential basis for distinguishing terminal sedation from euthanasia, the physician's intent, also fails. The physician's intent is morally equivalent for terminal sedation and euthanasia. As the *Quill* Court observed, considerations of intent are commonly invoked to explain the distinction between treatment withdrawal and assisted suicide or euthanasia.<sup>57</sup> According to the Court, a physician who withdraws life-sustaining treatment may only intend to free the patient of an undesired treatment, while a physician assisting a patient's suicide must necessarily

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*Physician-Assisted Suicide, A Very Modest Revolution*, 38 B.C. L. REV. 443, 447-49 (1997), my purpose is to show that, even if we accept the distinction, terminal sedation amounts to euthanasia.

55. Cf. *Gray v. Romeo*, 697 F. Supp. 580, 589 (R.I. 1988) (observing in a case involving the removal of a feeding tube from a woman who was permanently unconscious from a cerebral hemorrhage that "there is an obvious distinction between deliberately ending a life by artificial means and allowing nature to take its course"); *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (stating in a case involving the treatment of a bedridden woman with severe dementia that "[r]efusing medical intervention merely allows the disease to take its natural course").

56. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 206-11 (4th ed. 1994).

57. *Quill*, 117 S. Ct. at 2298-99.

intend the patient's death.<sup>58</sup> Indeed, the Court observed, the law commonly uses the intent of the actor "to distinguish between two acts that may have the same result."<sup>59</sup> The difference, in short, is between the person who acts "because of a given end" and the person who acts "in spite of" . . . unintended but foreseen consequences."<sup>60</sup>

These points about intent place terminal sedation in the category of euthanasia rather than withdrawal of treatment. As the *Quill* Court suggested, there are two components to the issue of intent—the subjective motivation or purpose of the actor, and objective considerations like the knowledge of the actor and the consequences of the action.<sup>61</sup> In terms of the subjective component of intent, we cannot distinguish terminal sedation from euthanasia. Indeed, we cannot distinguish among withdrawal of treatment, terminal sedation, assisted suicide or euthanasia. With all four, the physician acts with a morally acceptable, indeed morally praiseworthy, purpose: to relieve the patient's suffering and/or to free the patient of unwanted treatment.<sup>62</sup>

Although treatment withdrawal is typically distinguished from euthanasia in terms of the objective component of intent, terminal sedation and euthanasia cannot be differentiated on that basis. Treatment withdrawal is distinguished from euthanasia because with the former, the physician might reasonably believe that the patient will survive the discontinuation of treatment. The physician may have misjudged either the patient's dependence on the treatment,<sup>63</sup> or the chances that the patient's condition would improve.<sup>64</sup> Because it is possible for treatment to be withdrawn and for the patient to survive, we can say that the physician only intends to free

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58. *See id.*

59. *Id.* at 2299.

60. *Id.* The Court overstated its point. With most crimes, liability is imposed whether the defendant desired the result or merely acted with the knowledge that the result would occur. *See United States v. Bailey*, 444 U.S. 394, 404 (1980). In addition, even when the defendant's purpose or motivation is relevant, it usually affects only the degree of the crime and the severity of the punishment, not whether a crime has been committed. *See id.* at 405. Thus, the law often holds people responsible for the foreseeable consequences of their acts, even if they had no desire to cause those consequences. *See id.* at 404; W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 280-300 (5th ed. 1984). Typically, it is relevant whether the person acted with knowledge that the action would cause the results that occurred. *See WAYNE R. LAFAYE & AUSTIN W. SCOTT JR., SUBSTANTIVE CRIMINAL LAW 305-309 (1986).*

61. *See LAFAYE & SCOTT, supra* note 60, at 302-09.

62. *See Glucksberg*, 117 S.Ct. at 2310 (Stevens, J., concurring) (noting that, with either treatment withdrawal, terminal sedation, or assisted suicide, the "physician may seek simply to ease the patient's suffering and to comply with her wishes").

63. For example, the patient thought to be dependent on a ventilator for breathing may turn out to be able to breathe without a ventilator.

64. For example, the patient who is unable to eat or drink without a feeding tube may recover enough to start eating and drinking again.

the patient from an unwanted treatment. We cannot make a parallel argument for euthanasia. Because euthanasia will relieve the patient's suffering only by killing the patient, the physician cannot reasonably intend that the patient not die. In terms of this distinction between treatment withdrawal and euthanasia, terminal sedation falls on the euthanasia side of the line. Just as a physician performing euthanasia must necessarily intend the patient's death, because the patient will certainly die,<sup>65</sup> so must a physician providing terminal sedation intend the patient's death when the sedation is accompanied by the withholding of nutrition and hydration. Because no one can survive very long without sustenance, the withholding of food and water will inevitably cause the patient's death. In other words, there is no possibility that the physician has misjudged the patient's dependence on the treatment. Moreover, the sedation precludes the possibility of patient survival from a mistaken prognosis. Even if there is an improvement in the patient's underlying condition, the sedation will prevent the patient from starting to eat or drink.<sup>66</sup> Accordingly, if the physician's intent is the key, terminal sedation is still more like euthanasia than like withdrawal of treatment.

A fourth ground might also be used to distinguish terminal sedation from euthanasia: although terminal sedation may sometimes be euthanasia in form, it arguably is not euthanasia in substance. Physicians use terminal sedation to respond to the intolerable suffering of dying patients. Euthanasia, on the other hand, may be used to end the lives of disabled patients, without their consent. This argument for terminal sedation, however, is exactly the argument used by proponents of assisted suicide before the Supreme Court. In their view, assisted suicide should be permitted as long as

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65. The Court, like many commentators, mistakenly believes that with assisted suicide, the physician also must necessarily intend the patient's death. See *Quill*, 117 S. Ct. at 2299. In fact, a physician assisting a patient's suicide need not intend the patient's death. Many patients who receive a lethal supply of a drug never use it. See Meier et al., *supra* note 17, at 1195 (finding that 41% of patients who received a prescription from their physician for assisted suicide did not use the prescription). Knowing this, the physician might hope that writing the prescription for an overdose of barbiturates will relieve the patient's desire for death. Often, patients seeking suicide are primarily trying to assert control over their lives at a time when they are being controlled by their disease and their health care providers. See Daniel W. Brock, *Voluntary Active Euthanasia*, 22(2) HASTINGS CENTER REP. 10, 11, 15 (1992). Having the prescription or the bottle of pills in a bedside drawer can transfer enough control back to the patient for the patient to be willing to continue living. See Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, *supra* note 51, at 2026.

66. This fact distinguishes the terminally sedated patient from other patients, like Nancy Cruzan, whose feeding tubes are withheld. In theory, it was possible for Ms. Cruzan to recover her ability to eat and drink after her feeding tube was removed.

physicians use it only to respond to the intolerable suffering of dying patients.<sup>67</sup>

Finally, it might be asserted that with terminal sedation, the patient's death is actually the result of the underlying disease, rather than the physician's action. According to this argument, it is the patient's illness that creates the need for the sedation. The underlying disease is responsible for the patient's suffering and for the patient's request for palliative care. But this same logic would also justify euthanasia and assisted suicide. With euthanasia or assisted suicide, it is the patient's underlying disease that causes the patient to ask for a life-ending drug.<sup>68</sup>

#### IV. Terminal Sedation vs. Assisted Suicide

Terminal sedation is not only a type of euthanasia, it is also ethically more problematic than either assisted suicide or euthanasia. With respect to euthanasia, terminal sedation poses the same risks of abuse while serving fewer purposes of right-to-die law. Compared with assisted suicide, terminal sedation poses even greater risks of abuse and serves fewer purposes of right-to-die law.

Terminal sedation serves fewer purposes of right-to-die law than either assisted suicide or euthanasia for several reasons. A patient's right to refuse life-sustaining treatment is recognized in large part because of the pain and suffering caused by the patient's illness. With respect to this pain and suffering, terminal sedation provides the same relief as assisted suicide or euthanasia. The right to refuse life-sustaining treatment, however, responds to other concerns of dying patients. These other concerns are met

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67. See, e.g., Brief for Respondents, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110). Another response to this purported distinction between terminal sedation and euthanasia is that terminal sedation can also be used to end the lives of patients without their consent. See *infra* text accompanying note 83.

68. Still, some might say, if terminal sedation is euthanasia, then so are many other withdrawals of treatment that we would not want to consider euthanasia. Suppose, for example, that a patient undergoes surgery for coronary artery disease and during surgery suffers a stroke that leaves the patient mentally incompetent and dependent on a ventilator. Suppose further that the patient had given instructions that, in the event of irreversible incompetence, treatment with a ventilator was not wanted. If the patient's ventilator were then withdrawn, it would be odd to say that the withdrawal constituted euthanasia because the patient's inability to breathe was not the natural result of his underlying disease, but was the result of the surgical intervention of his physician.

We can characterize terminal sedation as euthanasia without being forced to characterize other withdrawals of treatment as euthanasia. In my example of the surgically-induced inability to breathe, the patient's stroke is at least as much a consequence of the patient's underlying illness as a consequence of the surgical intervention. More importantly, the surgeon does not intend to render the patient unable to breathe. In contrast, with terminal sedation, the physician acts intentionally to render the patient unconscious.

by assisted suicide and euthanasia, but not by terminal sedation. Patients who undergo terminal sedation are required to accept a dying process that is prolonged relative to the dying process with assisted suicide or euthanasia. Terminal sedation thereby forces patients to linger in a state that they may feel is profoundly compromising of their dignity, that further distorts the memory they leave behind, and that means a drawn-out and debilitating process for family members.<sup>69</sup> Terminal sedation also prevents patients from retaining a sense of control over the timing and circumstances of their death, a factor that may be critical to the psychological well-being of dying patients. Dying patients have little control over their lives. Critical matters will be determined almost entirely by their disease: How much longer they will live; where they will spend the remaining days or months of their lives; how many of their routine activities they will be able to manage by themselves; and how much discomfort they will have. In addition, if they are in a hospital or other institution, their schedules will be determined in large part by the needs of their health care providers. The option of assisted suicide gives patients more control because they ultimately decide when they will die.<sup>70</sup> In sum, terminal sedation is as beneficial to patients as assisted suicide or euthanasia in terms of relieving physical pain and distress, but it is less beneficial in terms of the other concerns that patients have about their deaths.

To see how terminal sedation raises the same risks of abuse as assisted suicide or euthanasia, consider the following twist on the Janet Adkins case. Janet Adkins was the woman who became the first person to die with the assistance of Dr. Jack Kevorkian.<sup>71</sup> Ms. Adkins was a 54-year-old woman from Portland, Oregon who was experiencing early symptoms of Alzheimer's disease.<sup>72</sup> She apparently tried several experimental therapies

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69. Cf. *Cruzan*, 497 U.S. at 310-312 (Brennan, J., dissenting) ("For many, the thought of an ignoble end, steeped in decay, is abhorrent. . . . A long, drawn-out death can have a debilitating effect on family members. . . . For some, the idea of being remembered in their persistent vegetative state rather than as they were before their illness or accident may be very disturbing."); James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. (1975) (observing that euthanasia is preferable to withdrawal of treatment since it minimizes the suffering of the patient, and the relief of suffering is what prompts a decision to withdraw treatment).

On the other hand, for some patients and families, a longer dying process may be desired. See Ira R. Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9(3) J. PALLIATIVE CARE 25, 27-28 (1993) (discussing the benefits of the dying process for patients and their families). Nevertheless, that is only an argument for allowing patients to choose whether to prolong their death.

70. See Robert F. Weir, *The Morality of Physician-Assisted Suicide*, 20 L. MED. & HEALTH CARE 116, 123-124 (1992).

71. See Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, N.Y. TIMES, June 6, 1990, at A1.

72. See *id.* at B6.



unsuccessfully, and then turned to Dr. Kevorkian for assistance in suicide.<sup>73</sup> In June 1990, she ended her life with the help of Dr. Kevorkian.<sup>74</sup> Now, suppose that when Ms. Adkins expressed her despair to her personal physician and her desire to obtain Dr. Kevorkian's assistance, the physician suggested that she consider instead terminal sedation accompanied by the withholding of nutrition and hydration. If we are troubled by Ms. Adkins' suicide at the hands of Dr. Kevorkian, then we should be equally troubled by the idea of terminal sedation at the hands of her personal physician. In both cases, Ms. Adkins would have died, despite not being terminally ill. In both cases, Ms. Adkins might have chosen to end her life because her mental competence was compromised by her Alzheimer's disease or by a depression that would have responded to psychiatric therapy.<sup>75</sup> In both cases, Ms. Adkins might have been pushed to end her life by her family or her physician because of their concerns about the costs of her care or the emotional burdens of caring for her.<sup>76</sup> In both cases, Ms. Adkins might have chosen to end her life because she did not receive appropriate palliative care for her suffering.<sup>77</sup> Finally, in both cases, Ms. Adkins might have been mistakenly diagnosed as having Alzheimer's disease.<sup>78</sup>

If we look at the other concerns about legalizing assisted suicide or euthanasia, we see that they apply in the same way to terminal sedation. If physician-assisted suicide or euthanasia would "undermine the trust that is essential to the doctor-patient relationship" because physicians would be causers of death as well as healers of illness,<sup>79</sup> then the practice of terminal

73. See *id.*

74. See *id.* at A1.

75. If, as the *Glucksberg* Court opined, legalizing physician-assisted suicide "could make it more difficult for the State to protect depressed or mentally ill persons . . . from suicidal impulses," 117 S. Ct. at 2273, then so could the legalization of terminal sedation.

76. Cf. Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23(3) HASTINGS CENTER REP. 32, 39 (1993) (raising these concerns as an argument against physician-assisted suicide). See also MARGARET PABST BATTIN, *ETHICAL ISSUES IN SUICIDE* 215-18 (1995) (acknowledging these concerns with assisted suicide but concluding that they can be addressed through regulation rather than prohibition).

77. Cf. Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 NOTRE DAME L. REV. 519, 531-32 (1995) (raising this concern as an argument against physician-assisted suicide).

78. We might distinguish terminal sedation with Ms. Adkins' Portland physician from assisted suicide with Dr. Kevorkian on the ground that Ms. Adkins had a long-standing relationship with her Portland physician. However, we can overcome that distinction by changing the hypothetical to involve a comparison between terminal sedation by the Portland physician and assisted suicide by the Portland physician.

79. *Glucksberg*, 117 S. Ct. at 2273. For other arguments making this point, see Leon Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, 94 PUBLIC INTEREST 25, 35 (Winter 1989) and Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 829 (1995).

sedation will also undermine patient trust. With terminal sedation, the physician is also hastening death rather than healing disease.

Commentators observe that physician assisted suicide is also dangerous because physicians undervalue the lives of persons who are terminally ill, elderly, or disabled. Therefore, they argue, a physician is less likely to question suicidal impulses when the patient is terminally ill, elderly, or disabled rather than young and healthy.<sup>80</sup> Terminal sedation, however, is similarly dangerous. When deciding whether to provide terminal sedation to a terminally ill, elderly, or disabled person, undervaluation of the person's life will make the physician more likely to provide the sedation than if the patient is a young, healthy person. Finally, if a right to assisted suicide for the terminally ill must inevitably lead society down the slippery slope to assisted suicide for patients who are not terminally ill,<sup>81</sup> then terminal sedation for the terminally ill will also inevitably lead to terminal sedation for patients who are not terminally ill.<sup>82</sup> All of the risks of abuse that exist for assisted suicide or euthanasia also exist for terminal sedation.

Terminal sedation also shares a serious risk with euthanasia that goes beyond the risks associated with assisted suicide. While it is not possible to coerce unconscious or severely demented persons to commit suicide,<sup>83</sup> it is a simple matter to terminally sedate, or perform euthanasia on, any incompetent person without the person's consent or even the person's knowledge. The death-causing act of assisted suicide is much more under the control of the patient than are the death-causing acts of terminal sedation and euthanasia.

In sum, when it comes to the issues that really count in determining the morality of a death-causing act by physicians—whether the act serves the purposes of right-to-die law and whether the act threatens patient welfare—terminal sedation is a worse alternative than either euthanasia or assisted suicide.

The Court's preference for terminal sedation over assisted suicide is puzzling. Not only is terminal sedation akin to euthanasia, a practice generally considered less acceptable than assisted suicide,<sup>84</sup> it ultimately

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80. See *Glucksberg*, 117 S. Ct. at 2273-74.

81. See *id.* at 2274.

82. Similarly, if it is not feasible to limit assisted suicide to the terminally ill because physicians cannot define terminal illness with sufficient precision, see Thomas J. Marzen, "Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill, 21 HASTINGS CONST. L.Q. 799, 814-815 (1994), it is also not feasible to limit terminal sedation to the terminally ill.

83. These persons are unable to take pills themselves. See Marcia Angell, *The Supreme Court and Physician-Assisted Suicide: The Ultimate Right* 336 NEW ENG. J. MED. 50 (1997).

84. See, e.g., Sidney H. Wanzel et al., *The Physician's Responsibility Toward Helplessly Ill Patients: A Second Look*, 30 NEW ENG. J. MED. 844, 848 (1989) (observing that euthanasia is

leaves patients with an option that is ethically more problematic than the rejected practice of assisted suicide. Accordingly, the Court has preserved the distinction between treatment withdrawal and assisted suicide only by creating a constitutional scheme that is inferior to a regime in which there is a constitutional right to physician-assisted suicide.

Note the irony here. The Supreme Court rejected a right to assisted suicide in large part because of the risks that it poses.<sup>85</sup> Yet, by sanctioning terminal sedation—a practice with greater risks—the Court implicitly took the view that the risks of legalizing physician-assisted suicide can be sufficiently minimized. In other words, the Court must have concluded that physicians can be trusted to offer terminal sedation in appropriate situations without offering it in all situations. More specifically, the Court must have concluded that physicians will reserve terminal sedation accompanied by the withholding of nutrition and hydration for patients who meet certain criteria, such as terminal illness or intolerable suffering.<sup>86</sup>

Once the Court has accepted the idea that terminal sedation can be used and reserved for only appropriate situations, despite its being a form of euthanasia, the Court has undermined one of its own critical arguments against physician-assisted suicide (or euthanasia). Many opponents of assisted suicide concede that it is morally acceptable in some circumstances, such as for the person who is suffering severe and intractable pain and who will die shortly from metastatic cancer. These opponents argue, however, that it is not possible to limit assisted suicide to only the morally acceptable cases. Once we permit assisted suicide for some persons, we will have no principle for denying it to other persons who claim great suffering.<sup>87</sup> The *Glucksberg* Court made the same argument.<sup>88</sup> Yet, if physicians can limit terminal sedation to appropriate cases, then they could limit assisted suicide in the same way. By whatever criteria physicians employ to decide when terminal sedation is appropriate therapy, they could also decide when assisted suicide is appropriate therapy.

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“even more controversial” than assisted suicide because it “requires the physician to perform a medical procedure that causes death directly”).

85. See *Glucksberg*, 117 S. Ct. at 2272-75.

86. This conclusion distinguishes terminal sedation from withdrawal of life-sustaining treatment, a practice that we are willing to permit for all persons.

87. See Daniel Callahan, *When Self-Determination Runs Amok*, 22(2) HASTINGS CENTER REP. 52 (1992); Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735 (1995).

88. *Glucksberg*, 117 S. Ct. at 2274 (recognizing that “the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia”).

## V. Explaining the Court's Reasoning

If terminal sedation essentially amounts to euthanasia in many cases, and if terminal sedation is more problematic ethically than assisted suicide, why did three Supreme Court Justices explicitly endorse the practice while rejecting assisted suicide, and why did the other Justices signal their approval of terminal sedation?<sup>89</sup> Might the Justices have misunderstood how terminal sedation actually works? This explanation is unlikely; the lawyers for the patients and physicians seeking recognition of a right to assisted suicide called the Court's attention to the similarities between terminal sedation and assisted suicide in both their briefs<sup>90</sup> and their oral arguments.<sup>91</sup>

In explaining the Court's decisions, there are two issues to be addressed: (1) Why would the Court endorse a practice that is essentially euthanasia? (2) Why would the Court reject the ethically superior alternative of assisted suicide?

I believe there are two parts to answering this question of why the Court would endorse a form of euthanasia. First, the Court's decision suggests that it cares more about why a patient wishes to die than how the patient dies. In endorsing terminal sedation despite the fact that at times it amounts to euthanasia, the Court is essentially saying that the right to die primarily reflects a moral sentiment that people who are dying and suffering intolerably should be allowed to die even if they cannot do so simply by refusing life-sustaining treatment.<sup>92</sup> In this view, it is more acceptable for a person who is suffering severe pain and who will die within a few days to receive terminal sedation than for a young, healthy person to refuse a ventilator when artificial ventilation is needed for only a few days as part of the treatment for a curable pneumonia.<sup>93</sup>

The second part of the explanation for the Court's acceptance of terminal sedation is that the Court saw a right to terminal sedation as neces-

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89. See *supra* notes 39 and 41 for discussion of the other six justices' implicit support of terminal sedation.

90. See Brief of Respondents at 21-22, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110); Brief of Respondents at 48-50, *Quill v. Vacco*, 117 S. Ct. 2293 (1997) (No. 95-1858).

91. See *Arguments Before The Court: Health Care*, 65 U.S. L. WKLY. 3481, 3483 (Jan. 14, 1997) (reporting that Justice Ginsburg at oral argument "questioned whether there is a rational distinction between such 'terminal sedation' and administration of a lethal pill"). Indeed, the Court discussed the distinction between terminal sedation and assisted suicide in its opinion in *Quill*, 117 S. Ct. at 2301 n.11.

92. See David Orentlicher, *The Legalization of Physician Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443, 462-71 (1997); David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 NEW ENG. J. MED. 663 (1996).

93. See *id.*

sary to preserve a patient's right to refuse life-sustaining treatment. Consider the following example: After being diagnosed with cancer and told to expect to live only another year or two, a patient writes a living will stating that, in the event of incompetence and imminent death, all life-sustaining treatment should be withdrawn. Several months later, the cancer is widely metastatic with death expected in a few weeks, and the patient is suffering from severe pain that cannot be relieved by analgesics. The patient's physician discusses the possibility of terminal sedation for the pain, and the patient agrees. The patient then reminds the physician of the living will and solicits a promise that the physician will carry out the instructions in the will. This would mean that, once the sedation left the patient incompetent, all life-sustaining treatment would be withdrawn or withheld. However, if the prohibition of euthanasia meant that patients receiving terminal sedation could not have food and water withheld, then the physician would have to refuse the patient's request. Patients like this hypothetical patient would have to choose between obtaining relief from their suffering or retaining their right to refuse life-sustaining treatment. This is a choice that people should not have to make.<sup>94</sup> Even for patients who have not already considered whether they wish to have life-sustaining treatment withheld when they ask for or agree to terminal sedation, it is still a problem if their physicians must tell them to choose between gaining relief for their suffering and exercising their right to refuse a feeding tube.

Although we have a good explanation for the Court's decision to accept terminal sedation despite the fact that it is a form of euthanasia, we are still left with the question why the Court would reject the ethically better alternative to terminal sedation of assisted suicide. Assisted suicide looks very different in a world with terminal sedation than in one without

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94. The Court has been concerned about forcing people to make "Hobson's choices" in other contexts. For example, in *Dunn v. Blumstein*, the Court invalidated certain residency requirements for voting in state elections on the ground that the requirements forced people to choose between their right to travel and their right to vote. 405 U.S. 330, 342 (1972). Similarly, the Court has held in several cases that individuals cannot be penalized for exercising their Fifth Amendment privilege against self-incrimination. See, e.g., *Malloy v. Hogan*, 378 U.S. 1 (1964) (individual cannot be held in contempt of court for invoking Fifth Amendment); *Spevack v. Klein*, 385 U.S. 511 (1967) (lawyer cannot be disbarred for invoking the Fifth Amendment in professional disciplinary hearing); *Gardner v. Broderick*, 392 U.S. 273 (1968) (policeman cannot be fired for invoking the Fifth Amendment even when being questioned with regard to official duties). This unfair choice problem is similar to, although stronger than, an unconstitutional conditions case in which the government conditions a benefit on the waiving of a constitutional right. For discussion of the unconstitutional conditions doctrine, see Kathleen M. Sullivan, *Unconstitutional Conditions*, 102 HARV. L. REV. 1415 (1989); Cass R. Sunstein, *Why the Unconstitutional Conditions Doctrine Is an Anachronism (with Particular Reference to Religion, Speech, and Abortion)*, 70 B.U.L. REV. 593 (1990).

terminal sedation. Once terminal sedation is available, permitting assisted suicide reduces, rather than increases, the risks of patient abuse.<sup>95</sup>

The Court's decision to reject assisted suicide despite its acceptance of terminal sedation appears to reflect considerations of symbolism. While it is true that terminal sedation can effectively constitute euthanasia, and that terminal sedation can be abused more than assisted suicide, terminal sedation looks on the surface more like the accepted practices of aggressive comfort care and treatment withdrawal than like assisted suicide or euthanasia. Moreover, in practice, it appears to be limited to only appropriate cases. No one is suggesting that physicians are administering terminal sedation to people who are not seriously ill or who really should be treated with psychological counseling and anti-depressive drugs.<sup>96</sup> In contrast, there is real concern that Dr. Kevorkian is assisting the suicides of persons who are not seriously ill or who have serious psychological problems.<sup>97</sup> In addition, there are many suicides in this country that are committed by people who are psychologically depressed, but who have no serious physical illness. The Court may have been concerned about the message to these people if assisted suicide for terminally ill persons was permitted.<sup>98</sup>

Nevertheless, the Court's deference to symbolic considerations creates its own problems of symbolism—assisted suicide is rejected only by embracing euthanasia. Moreover, the symbolic benefits come at a significant cost to patients. As discussed, the patients who are denied assisted suicide, and who therefore must choose terminal sedation, are forced into a less desirable alternative. In addition, the permissibility of terminal sedation poses greater risks than assisted suicide for incompetent patients who would not want to die, but whose families or physicians think ought to die.<sup>99</sup>

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95. As discussed, *supra* text accompanying notes 71-83, terminal sedation poses greater risks to patient welfare than does physician-assisted suicide.

96. To be sure, this might reflect the fact that terminal sedation is not used very widely. As physicians begin to use it more, the chances of abuse will increase.

97. See *Clash in Detroit Over How Ill a Kevorkian Client Really Was*, N.Y. TIMES, Aug 20, 1996, at A13.

98. See *Glucksberg*, 117 S. Ct. at 2272 (discussing the seriousness of suicide as a public health problem).

99. Such thoughts may reflect genuine efforts to carry out the patient's interests or might reflect subconscious responses to the burdens of caring for the patient or the economic constraints of managed care.

## VI. Conclusion

Beneath the Supreme Court's apparent adherence to the distinction between treatment withdrawal and assisted suicide or euthanasia is a blurring of that distinction. By accepting—even endorsing—terminal sedation while rejecting assisted suicide, the Court has given physicians permission to employ a treatment that is essentially a form of euthanasia.

In some ways, this is an appropriate step. It permits patients to retain their ability to avoid severe suffering without having to sacrifice their right to refuse life-sustaining treatment in the process. It also elevates function over form. As a type of euthanasia, terminal sedation is problematic in its form. Nevertheless, the Court's acceptance of the practice is a signal that the overriding consideration in right-to-die law is the moral sentiment that dying patients who are suffering intolerably should be able to end their lives, even if they have to do so via euthanasia.

There are also serious problems with the Court's approach. By choosing terminal sedation over assisted suicide, the Court has taken a path that is ethically more problematic than the alternative of recognizing a right to assisted suicide. Terminal sedation serves fewer of the purposes of right-to-die law while posing a greater threat to patient welfare.

All of this suggests that the states are likely to gradually lift their prohibitions against physician-assisted suicide.<sup>100</sup> Because terminal sedation serves fewer of the purposes of right-to-die law than assisted suicide, there will still be important unmet needs of dying patients. In addition, because the availability of terminal sedation means that legalizing physician-assisted suicide will reduce rather than increase the risks to patient welfare, assisted suicide can be justified in terms of protecting patients from abuse.

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100. The states will no doubt consider the experience of Oregon with assisted suicide, now that the state's voters have reaffirmed Oregon's assisted suicide statute, and the Supreme Court has declined to consider a legal challenge to the statute.